DOCUMENT RESUME

ED 179 879 CG 014 024

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TITLE Federal Leadership in the Primary Prevention of Mental and Emotional Disabilities.
PUB DATE Sep 79
NOTE 14p.: Paper presented at the Annual Convention of the American Psychological Association (87th, New York, NY, September 1-5, 1979)

EDRS PRICE MF01/PC01 Plus Postage.
DESCRIPTORS *Emotionally Disturbed: *Federal Aid: *Federal Legislation: Federal Programs: *Financial Policy: *Financial Problems: Health Programs: *Mental Health Programs: *Prevention

ABSTRACT

Two basic issues in mental health are how tax monies and resources are being allocated and how the resources are being spent. More could be spent in the area of mental health prevention rather than in treatment. Prevention is action that prevents significant diminishment of function, or the development of organic disability, as a result of mental-emotional disturbance. Federal health dollars are currently being spent in an illogical way. Statistics suggest that the federal health authorities are not utilizing a process which results in realistic and effective targeting of resources to the problems. The highest and most pressing health priority should be to determine and acknowledge what causes disability and premature death, and what accounts for nonproductivity, and then to allocate resources to alleviate these problems. (Author/BMW)

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ED179879

Invited Address

American Psychological Association
Annual Meeting
September, 1979
New York

# "FEDERAL LEADERSHIP IN THE PRIMARY PREVENTION OF MENTAL AND EMOTIONAL DISABILITIES"

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CG 014024

U.S. DEPARTMENT OF HEALTH, EDUCATION & WELFARE
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The title of this presentation is "Federal Leadership in the Primary Prevention of Mental and Emotional Disabilities." My experience through the years has not made me optimistic about leadership for prevention, but I can report that, in my view, at the moment, there are grounds for cautious optimism.

President Carter as head of the federal government has shown more interest in the area of mental health than any president since Kennedy, and he has supported making prevention a high priority. The attention that he and Mrs. Carter have brought to mental health provides the best chance in recent history to efforts to bring mental and physical health into an appropriate balance. Because of the serious inequity that currently exists, we must look at the relative attention directed to these two areas of health, before we can speak about prevention as a focus within mental health.

The basic trouble point is not after we start looking at mental health problems, but at the time when available resources are targeted for overall health.

One role of the federal government is to allocate tax dollars effectively, that is, for the benefit of the American people.

In the health field, tax monies and resources are not being allocated effectively. In fact, the government is spending vast amounts of money, an estimated $63 billion this year, on health, and utilizes no process for allocating the money so as to deal with health problems in relation to the disability caused. The money is being spent without a starting point, without regard to what the health programs are. Major adjustments are urgently needed. The federal government must develop a process and a structure so as to direct the resources, the monies to be spent, to the sources of the problems. If we look at the drain on our tax dollars, as well as at the human misery caused by mental disturbances, it is clear that the attention and allocation of resources to attaining and maintaining mental health is totally inequitable and disproportionate, Then, within the mental health allocations, the resources are too much on treatment and not enough on prevention.

These are the points I'd like to make this afternoon. First, federal health dollars, tax dollars, are being spent in an illogical way. And second, we're putting what resources there are into trying to treat mental illnesses, when we should be allocating a reasonable effort to trying to prevent it before it occurs. The two basic problems are very much interrelated.

First, let us look at overall health. In FY 1978, the people in the U.S. spent $180 billion on health care.* Health is the third biggest business in the U.S. The federal government, i.e., our taxes, pay for about one fourth of the costs.

I want to ask you, as professional people to answer a question. HOW MUCH OF HEALTH IS MENTAL HEALTH? During my year as a member of the President's Commission on Mental Health, I became more and more aware, and more and more puzzled about that basic fundamental question. It is so elementary that I have great difficulty understanding why it only remains unanswered, but is rarely asked. The facts are available and are clear, but they go unacknowledged. And the people that seem

*HEW Secretary Califano, October 26, 1979, before the National Academy of Sciences, Washington, D. C.

most abysmally tuned out, unaware and afflicted with tunnel vision, are the psychologists and psychiatrists, the vast majority, that is, certainly not any of you.

I imagine you are convinced that mental health is basic to health. I expect you would find it difficult to believe that a person can be healthy and mentally unhealthy. But answer this for me: Is mental health a subcategory of physical health like measles or nearsightedness or a broken leg?

I submit that mental health and mental disability are as basic to, are as complex and as related with overall health as is physical health and physical disability. I find it strange that the fundamental nature, the complexity of physical health and physical disability is acknowledged and recognized, but somehow that the existence of the same fundamental nature, the same complexity in mental health and mental disability is not acknowledged. Further, despite a great amount of documented data which shows the interrelationship of mental and physical health, the rhetoric acknowledgement is not reflected in resource allocation. And, we sit back and let the mental and emotional aspects of health be categorized, and resources be allocated in the same manner as a subcategory of physical health.

Let us look at the cost in dollars as one indicator of how much of health is mental health. In 1977, $17 billion was spent on direct mental health care in the U.S., 12% of total health care costs, (PCMH). However, 54% of those who received care for mental-emotional problems did so from primary care physicians (HEW News, May 15, 1979). We know, then, that the 12% is substantially under the total for direct costs since more than half of people treated were treated in non mental health facilities and by non mental health specialists, and therefore, the costs were not included in the above figures. In addition to those costs which don't show up in the 12%, we must take into account the extent to which emotional disturbance is either misdiagnosed or mislabeled as a physical problem. Also we should be able to estimate the part of physical disorder which is the result of psychological stress. Even if the most extremely conservative estimates were counted, the amount would be substantial.

Having added all those extra costs to the original 12% we still would not have accounted for the total costs. We must add the cost of drugs to the litany. Sixty-two percent of all prescribed drugs are for the alleviation of emotional symptoms.

In terms of total dollars spent for health, then, I would ask anyone to challenge an estimate that at least 50% is spent as a result of mental and emotional disturbances. I'm convinced that of the $180 billion that was spent on health in 1978, fully half, $90 billion, was spent as the result of mental and emotional dysfunction.

If dollars aren't your thing, let's look at other indicators. The Institute of Medicine* reported in 1976 that mental disorders led the list of reasons for hospital admissions and accounted for more days of hospitalization than any other cause. One third of the hospital beds are occupied by the diagnosed mentally ill. These, let's keep in mind, are the diagnosed mental disorders and do not include the diseases caused by psychological stress, but labeled as physical problems. So, how much of health is mental health? Or, to put the question differently, how much of health disorder is mental-emotional disorder?

*Rice, Feldman and White: The Current Burden of Illness in the United States. Institute of Medicine, 1976, Washington, D.C.

President John F. Kennedy in his message to Congress in 1963 acknowledged the enormity of the mental health problems. He said, "....mental illness and mental retardation are among our most critical health problems. They occur more frequently, affect more people, require more prolonged treatment, cause more suffering by the families of the afflicted, waste more of our human resources, and constitute more financial drain upon both the public treasury and the personal finances of the individual families than any other single condition."

President Carter, when he was governor of Georgia, also spoke of mental illness as the number one health problem. In an article entitled, "The Role of the Governor in Mental Health," he said, "Mental illness is the most costly health problem in America today, both in dollars and in wasted human lives."

What I want to know is - who believes that? Do you believe it? Do you believe that mental disorder is a serious health problem? Do you believe that tax dollars allocated to health should reflect the problems?

Let's look at the facts - let's look at what happens to our tax monies.

1. Of the total federal dollars allocated for health, less than 6% goes to alleviate mental affliction, and alcohol and drug problems.

2. In 1977, HEW's research budget was $2.6 billion. In 1977, the research budget for the Mental Health Administration was $108.9 million or 4.2$. If you add to the mental health research budget the money for Alcohol and Drug Research (42 million) it comes to about 6%.

I hope you believe that tax monies spent at the federal level for health should be targeted at the source of the problems. If you believe that, then you must be concerned, as I am, to see that the federal health authorities are not utilizing a process which results in realistic and effective targeting of resources to the problems. The highest and most pressing priority of the federal health authorities must be to determine and acknowledge what causes disability and premature death and what accounts for non productivity; to then allocate resources to alleviate the problems as they exist. There is, at present, no place that these overall decisions are made.

The National Health Planning and Resource Development Act of 1974 provides a structure which could be utilized for overcoming wasteful uses of health resources.

Planning processes are a mechanism through which tough decisions can be made within the intense political environment of bureaucratic survival, professional competition, and consumer demand.

However, as the law originally was written, mental health essentially was ignored. It defies logic that people who considered themselves to be "health" planners put mental health in the same category as measles or a broken bone. If I sound bitter it is because I remember so vividly when I and another Mental Health Association member called on a former director

of health planning pointing out the mental as well as physical health should be specified in the planning efforts. We were told that we must recognize that all special interests couldn't be named in the law, "after all," he said, "the podiatrists were here yesterday." Podiatry is, of course, an important sub-category of medicine, but is of a different dimension than is mental health.

It has taken four years and thousands of hours of effort to get amendments to the act which recognize that mental health is a part of health, and which now provide for some hope that duplicative and conflicting processes can be overcome. Perhaps some of the blatant neglect can now be overcome at the local levels, but we still do not have representation at the national level. The National Health Council does not even have token mental health representatives.

I remind all of us that it remains tragically true that the emotional and mental aspects of health are still often shunted aside and forgotten.

We might expect the National Health Council to be able to monitor the assessment of mental and physical health problems, the allocation of resources to alleviate the problems, and the processes to insure accountability. Thus far, however, the Council does not represent health matters since mental health is not appropriately recognized, and thus far, the opportunity has not been afforded it to serve as the central guiding force which is needed. No process is yet in place whereby the guidance expected from the council can be translated into rational planning, and allocation of resources, together with systematic assessment.

The urgency of finding a viable effective process is more than evident. In the area in which we are interested, it is clear that unless mental health is allocated resources commensurate with the depth and scope of the problems, there is little hope that progress can be made either in prevention or in treatment.

With that said about the number one problem, the illogical way that our tax dollars are spent on health, let us turn to the Prevention of Mental Disability.

First let me define what I mean by prevention. I do not mean treatment or early intervention after disability exists. My definition of preventive action is action that prevents significant diminishment of function, or the development of organic disability, as a result of mental-emotional disturbance.

It is very necessary that we have consensus as to what is meant by prevention in order to avoid re-labeling treatment processes as prevention.

So, now, what is there to be said about federal leadership in the prevention of mental and emotional disabilities?

Let's fantasize a bit. Let's pretend we have adequate resources. How should these resources effectively be targeted toward improving the mental health, and, therefore, the health of the individuals in the U.S.?

When we look at the overall mental health picture the first thing we become aware of is pain. There is pain out there. There are children whose lives may be lost unless somebody does something. There are adults who may lose their jobs, or commit suicide unless somebody helps them. There are older adults who are depressed and tragically unhappy.

Shall we spend money and direct resources to help?

Yes, I say. Yes, some of the resources.

Shall we allocate research money to search for better cures?

Yes, I say. Yes, some of the resources.

Certainly, resources must be allocated to treatment. We must treat as best we can, even though, as in the case of cancer and many of the physical illnesses, we do not always know enough to cure. Still, many can be helped, some can be made well. We must allocate some of the resources to treat those who are already afflicted.

It has been recognized, however, that there will never be enough personnel nor enough money to treat the mentally disabled. I don't think it necessary to review all the data which support that conclusion. I would only point out, that at yesterday's prices the average cost to the taxpayer of taking care of a disabled person is $27,000.00 a year.

So, each of us is paying a very very high dollar price, for every person who unnecessarily becomes a tax drain, instead of having been a contributor to the tax base.

The case for prevention has been made repeatedly. In almost every report, in every statement of responsibility, in the congressional charge everywhere - we find the words - about the federal health agencies' commitment to prevention. Yet in April, 1978 the President's Commission on Mental Health reported:

> "At present our efforts to prevent mental illness or to promote mental health are unstructured, unfocused, and uncoordinated. They command few dollars, limited personnel, and little interest at levels where resources are sufficient to achieve results. If we are to change this state of affairs, as we believe we must, the prevention of mental illness and the promotion of mental health must become a visible part of national policy."

We ask why? Why hasn't prevention been taken seriously? Why was there no rational planning, why so little personnel, why no money.

The reasons aren't hard to find.

The people who run the agencies are trained to treat the disabled. That is where their interest is. Further, the resources allocated are far from adequate to even do that.

Nevertheless, resources allocated from public monies must in the

future be directed at the overall good and should reflect the needs of the people. Cost/benefit analyses should be the basis of expenditures, not precedent and tradition.

The problems arise of course when a significant change in direction is indicated. But turf guarding cannot be tolerated when the situation has reached the proportions which now exist. I don't think it necessary to answer again some of the questions that continue to be asked such as "What is it that you want to prevent?" and "Do we know enough to prevent?" The cost of mental disability is sufficient to define what it is that we want to prevent, and the President's Commission Report and many, many other resources contain references so that those genuinely desirous of answering that question can locate ample areas of preventive activities which are known to be effective. They will also find hundreds of innovative ideas waiting to be tested.

But if we knew nothing -- nothing at all, we would have an even more compelling reason to mount an organized effort to prevent these disabilities.

When we don't know, or don't know enough, to solve serious and complex life defying issues, usually we get together at an appropriate level and figure out ways to go about finding out. We define a strategy; we define and set in motion a process carefully thought out to move toward a defined goal.

So, when the questions are, "What is it we want to prevent?" and "Do we know enough?" I think that the wrong people are asking the questions.

Resistance to change also is apparent when people seek to impose more stringent standards on the processes and outcomes of mental health efforts than on the processes and outcomes of efforts to alleviate physical problems.

In both areas the emphasis should be on quantitative measures of the results of the investment of resources, but we must be alert to the excessive demands of those who seek to ask more of mental health as compared with physical health. Also when excessive standards are demanded of prevention oriented efforts as compared with treatment oriented efforts.

I have become increasingly weary of those persons who fund or perform treatment services without documentation of outcome, and who then demand that those who perform prevention services provide clear evidence of outcome.

Another problem which has arisen in trying to balance the scales with regard to mental health is when those with commendable desire for the scientific method in all health research, let their voices be heard as speaking only for research in mental health.

All evidence points to great disparity in the level of effectiveness of many of the physical health therapies, potions, remedies and research efforts. I am not convinced that there is an enormous difference with regard to mental health. I am convinced that given a more logical portion of the resources over a reasonable period of time, the scales can be quite well balanced with regard to specificity of results when mental health is compared with physical health. And, that prevention of mental and emotional disorders as well as treatment of those that are not prevented, can be a reality.

There must be room for different approaches to seeking alleviation of disorder. Those who seek preventive methods must not be restricted to only those approaches which have been effective for some of the germ caused illnesses.

If, over the next decade we focus attention on these mental and emotional precursors of mental and physical disability, in a manner as strongly as we are now doing with cancer and some of the other physical manifestations of disability, we can predict reasonable success and a firm basis upon which to work toward the promotion of mental health, the prevention of mental illness, and the improved care of the mentally ill.

When a prevention focus is incorporated into the efforts of the federal agency responsible for mental health, I predict that we will see a much different structure. One in which efforts to prevent mental disability co-exist with efforts to treat disability. An agency in which those whose interest and training are in treating the disabled, will be the front line of guidance and help in developing the process and strategies to identify and reduce predisposing factors. I think that those who serve the disabled have a heavy responsibility to support efforts for prevention. They may not be the best people to do prevention, in fact, I feel it is unfair to expect that, but wholehearted support and help I believe, reflect the capacity to think in terms of the overall good, the public's health. It is going to take a high level of motivation and cooperation, and an ability to look beyond the existing situations.

I see a reallocation of effort and resources at ADAMHA, and its institutes, an expanded team of experts and teams who see prevention as important as treatment.

The current dilemma is that mental health dollars are now being directed toward the already disabled and essentially no dollars are on the side of prevention. Changing direction will be difficult in this area as well as in overall health.

The U.S. is not alone in its predicament. Canada has probably come closest to acknowledging and attempting to overcome barriers to locked in, ossified, and outdated health approaches.

In its 1974 document, "A New Perspective on the Health of Canadians," the government announced a new direction for the expenditure of resources, with emphasis on life style, environment, biology and with much less emphasis on ill health treatment. On page 6 of the report we find the following, "In taking these steps, the government of Canada, in cooperation with others, will pursue two broad objectives:

1. To reduce mental and physical health hazards for those parts of the Canadian population whose risks are high, and

2. To improve the accessibility of good mental and physical care for those whose present access if unsatisfactory."

Notice that mental and physical health are mentioned with equal emphasis and that prevention and treatment co-exist.

Our system of health is different from that of Canada. But the needs of people are pretty much the same and at this point in time there is no ongoing viable structure in the U.S. within which continuing objective assessment can be done either at the original allocation of health resources or after mental health is allocated its share. But we do have cause for optimism.

Why am I optimistic? What are the prospects for federal leadership in the prevention of mental and emotional disability?

Two and one half years ago there was no defined prevention program at NIMH. However, a man had become president who believed that prevention could be a cost effective part of the mental health effort. President Carter during his political life has sought to improve the conditions of the mentally disabled, and has consistently emphasized the urgent need for prevention. But, since he became president, it has been Mrs. Carter who has lifted mental health into the spotlight and has focused the nation's attention on the need to recognize that mental disability is a critical, pervasive, and life defying threat to overall good health. She has repeatedly raised the issue of the neglect of preventive action.

The President's Commission on Mental Health was created to review where the nation was and to focus attention on mental health.

With regard to prevention, the Commission reported that they found words but no substance to efforts to reduce mental disability through prevention; they recommended very specific actions.

The President directed that the recommendations be implemented. He requested the help of Congress in reaching the goals.

So what has happened, what has changed? Well, for a bureaucracy, perhaps we should feel that much has been accomplished. That sounds negative, but the fact is that change in the federal scene comes slowly, and that is the way it must be in order to maintain the checks and balances of our democratic system.

Following the President's directive the Department of Health, Education and Welfare analyzed the 117 recommendations and through administrative changes and through asking the Congress to legislate some changes, has moved forward on a number of the improvements sought.

In a letter dated July 5, 1979, Dr. Gerald Klerman, the Director of ADAMHA, states that he has elevated prevention to the fourth major mission of the agency's traditional activities of services, manpower, and research. It has been announced that a new organization in the office of the administrator includes a separate division for Prevention.

That sounds good to me. Since this has only been official a few weeks, I am not too disappointed to have seen no defined goals or plan of action. Those of us who are interested in the action part eagerly await the next step.

Another cause for optimism is the convening of the first nationwide annual ADAMHA conference on prevention. It will be held in Washington this month. I expect to see most of the outstanding advocates for prevention there, as well as enough skeptics to keep a good balance. Through this kind of forum we can predict that a focus can be kept on Prevention, and I have strong hopes that we may begin to see some real action.

Another item about which we can see hope is, in April, 1978, the National Academy of Sciences established a new Academy of Behavioral Medicine Research, to address new issues with regard to the changing "burdens of illness." Also in July 1979 the National Principles for Research were published by HEW, the result of a monumental effort to get a handle on the best way to allocate resources for research.

We have further reason for hope. The Surgeon General's Report on Health Promotion and Disease Prevention, a book entitled, Healthy People was released on July 28, 1979. (DHEW (PHS) Publication No. 79-55071). The report is a strong call to reorder our health priorities. "...It is clear that improvement in the health status of our citizens will not be made predominantly through the treatment of disease but rather through its prevention." The Surgeon General reported that a group of American experts (using the Canadian framework), developed a method for assessing the relative contributions which cause death and disease in relation to the ten leading causes of death of 1976. They report that perhaps as much as half of U.S. mortality was due to unhealthy behavior or lifestyle; 20% to environmental factors; 20% to human biological factors; and only 10% to inadequacies in health care.

Mental health is woven into much of the new report, in effect mental health has been mainstreamed in this new look at overall health. This can be tantamount to substantial progress, or it can be a regressive step. The outcome will depend on whether or not someone looks at the statistics which spell out the depth and scope of mental health as a part of health. If the Institute of Medicine's report on the Burden of Illness, and the inclusive cost of mental disability are considered as bases on which to allocate resources, well and good. But those of us interested in mental health as a part of health will have to watch very, very carefully to be certain that mental health is not treated like the minnow in the mainstream.

Also those interested in prevention of mental disability and promotion of mental health will need to support those aspects of the overall new approach.

It is a milestone report and, if there is a process and structure in place to implement its guidelines, we may see some real changes in direction, in the allocation of health resources at the federal level.

What else has happened? Is there a Center for Prevention at the NIMH? No, not yet -- and to tell the truth, I still don't know exactly who is in charge. I have not seen a defined process for determining long range goals, nor for setting priorities; I do not know whether there is substantial staff: I don't know yet whether the staff will be strong advocates for prevention, or whether they will be people whose background, interest, and experience have been in treatment. I don't yet have a good feel for whether the challenge to prevent elicits an enthusiastic and committed determination to be leaders, coordinators, and catalysts, or whether the view is one of having something imposed on an ongoing, already burdened

and underfinanced agency.

I am not suggesting that treatment oriented people be asked to suddenly become prevention oriented people. That really isn't fair. It is quite clear to me however, that for a successful redirection of effort, the people who are responsible for achieving the goals have to be believers, whether they come from those whose background is treatment, or whether they have evolved from more prevention oriented roots. For the discernible future, there will be enough skeptics to preclude the programs from running away with the agency.

I am looking forward to hearing what is happening in Prevention at the next NIMH Advisory Council meeting which is to be held this month.

So, with regard to the HEW responses to the call for federal leadership in prevention of mental and emotional disability, I think it is fair to say that from nothing, the federal leadership has come a long way. This time I hope the talk will turn into resources and programs.

Another aspect of federal leadership is, of course, the Congress. There is a bill being considered by Congress now called the "Mental Health Systems Act." It was initiated by HEW in response to the President's Commission report. The act has a title called Prevention. The major problem is that it does not mandate leadership from the federal agencies. Advocates for prevention prefer that the law mandate federal responsibility for leadership and coordination, especially in the light of the past history of neglect.

Fifty states doing what they call or somebody calls prevention, could be a program for failure. If we are to achieve prevention planning, implementation, and assessment, national leadership is critical. Suggested amendments have been offered through a coalition of groups including Community Mental Health Center Directors, State Mental Health Directors, the Mental Health Association and others, to make the legislation more specific with regard to the federal leadership role in primary prevention of mental and emotional disability. There is widespread support for the suggested changes in the pending legislation.

There are other signs of growing momentum toward prevention. Constituency groups are springing up all over. States and some regions are showing increased interest, professional groups and other groups are becoming vocal and insistent. An excitement is developing that from my perspective does not seem vulnerable to "put down." It is happening not only in Vermont, but in North Carolina, in Michigan, in Illinois, in Kansas, in Georgia, in children's coalitions and in some parts of HEW.

I would like to bring to your attention the process by which a program is being developed in Illinois. Emphasis is on planning, on a process of education, on systems, on a support constituency which

hopefully will facilitate and enhance careful prevention program planning and prevention service coordination. I think Illinois has moved ahead of the federal agency. Several such sophisticated approaches which are being generated at the state levels could contribute to devising an approach at the national level.

Other evidence of action is this organization's investment in a Task Force on Alternative Models for the Delivery of Psychological Services. The services named will include more than those designed to treat the already disabled. Also, the policy of the Association includes strong support of prevention activities, and testimony given on the hill recently clearly sets forth the stance of APA toward improvement in health as well as treatment. I hope to see an even more structured and formal investment of resources.

## SUMMARY

I have indicated that the allocation of federal funds for the improvement of health is illogical. That fully half the burden of illness is psychological in origin, that mental disorders lead the list as a cause of hospital admission, and that one-third of all hospital beds and hospital days are for the mentally disabled. Despite the depth and scope of mental health problems, the federal government allocates less than 6% of its health dollars to the alleviation of these problems. Further, and even more astounding, is the lack of research dollars allocated to mental health. Of the $2.6 billion allocated for health research, only 4.2% is specifically directed toward mental disorder.

The utilization of a structure and a process by which health needs of the public can be analyzed without regard to jurisdictions or special interests is urgently needed. The structure to serve this function must be balanced with regard to representation of mental as well as physical health. The public's interests must be represented as well as the provider. The results of such an objective assessment should be used as a basis for developing long range plans and for the allocation of resources.

The allocation of public money not only should reflect efforts to alleviate disability and dysfunction, funds must also be targeted to prevent disabling conditions from occurring. Tax monies should be utilized in a way that show costs and benefits, not continue to be tossed into the same funnels that have existed in past times. When costs and benefits are used to direct resource allocatio prevention will become a viable program.

In the case of mental health as well as general health, when resources are allocated, more is expected than to take care of the already disabled. There must be a concerted, sustained, committed effort to finding the antecedent factors, to reducing the hazards, to stopping the noxious process or processes before harm is done. Also there must be recognition that neither preventive programs nor treatment programs are easy to evaluate, but that the best systems available must be used to test our efforts. But we keep it balanced.

We do not let opponents require one set of stringent standards for preventive efforts, and another less stringent set for treatment. We protest and demand equal treatment when efforts to improve the scientific method are focused exclusively on mental health and not on physical health. We do likewise when more is demanded of prevention oriented efforts than is asked of treatment oriented effort.

What is requested is resources to define and implement a strategy to prevent some of the problems. No one has offered miracles, not outlandish prophecies of preventing all the problems, nor a predetermined set of plans. As serious proponents for prevention we insist that prevention efforts be managed, planned, implemented and assessed in a businesslike manner, and we insist that treatment efforts be equally accountable.

I am optimistic that there is movement towards these mental health and mental disability prevention goals at the federal level, primarily due to the active interest of President and Mrs. Carter. A new office has been created within ADAMHA, with a special section for prevention. A milestone report from the Surgeon General has called for the reordering of our health priorities with more emphasis on health and on prevention. There are new bills in Congress, new amendments to old Acts, and new programs in federal agencies which move us in the right direction. And there is grassroots support by many states and by many organizations, including the APA.

But the goals are difficult, exceedingly complex and will require continued, unrelenting commitment and effort along with the acknowledgement that we cannot see results tomorrow. This is true for the fight against cancer, coronary heart disease, against a lack of energy, and against all the major detriments to fulfillment of living. It is no less true for the goal of mental health. Despite the problems and the complexities, I submit that there exist today a range of techniques that can be used and can result in plans and implementation of plans that will lead towards improved mental health. I am also aware, however, that there is no way at all for achieving these goals unless there is a focus on the problems, a mandate for action and an assignment of responsibility. We must allocate our health resources in a way that is commensurate with the depth and scope of the problems. Then, and only then, will there be hope for prevention and treatment of mental illness.

Thank you.